MISSOURI DEPARTMENT OF REVENUE
CUSTOMER ASSISTANCE BUREAU

VISION EXAMINATION RECORD

FORM **999** (REV. 7-03)

VOID IF ERASED/ALTERED OR NAME/DATE OF BIRTH NOT INCLUDED

DATE	NAME

ADDRESS	CITY

DRIVER LICENSE NUMBER

DATE OF BIRTH	SOCIAL SECURITY NUMBER

APPLICANT'S SIGNATURE - **MUST BE SIGNED IN PRESENCE OF DOCTOR**

ACUITY	LEFT	BOTH	RIGHT
NO AID	20/	20/	20/
COR-RECTED	20/	20/	20/
FIELD	°	°	°

DATE REFERRED TO DR.	RESTRICTIONS

CLERK OR VISION TESTER SIGNATURE

EYE DOCTOR'S OR PHYSICIAN'S REPORT

• 20/40 IN EITHER OR BOTH EYES MINIMUM STANDARD FOR MISSOURI LICENSE.

NOTE: SPECIAL RESTRICTIONS CAN BE ADDED TO LICENSE IF REQUIRED DUE TO VISUAL CONDITION. SPECIFY BELOW.

REMARKS

DISTANT VISION ONLY	RIGHT	LEFT	BOTH
CORRECTED	20/	20/	20/
WITHOUT CORRECTION	20/	20/	20/
HORIZONTAL FIELD IN DEGREES	°	°	°

EYE DOCTOR'S OR PHYSICIAN'S SIGNATURE	DATE OF EXAM

ADDRESS

CITY, STATE, ZIP CODE

PHONE	REGISTRATION NUMBER
( )	

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